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ABSTRACT

A model program designed to integrate 6 handicapped with 9 nonhandicapped preschoolers in a training hospital setting was set up through the cooperative efforts of Head Start and the University Affiliated Program (UAP) at Children's Hospital (Los Angeles, California). The program offered a combination of comprehensive health care and integrated educational services to low-income children and their families and provided interdisciplinary inservice training in special education to both Head Start and UAP staff members. Training consisted of seminars on subjects such as classroom techniques, information regarding handicapping conditions, staff attitudes toward the handicapped child, and skills in working with parents as well as through observation and direct classroom participation with the children and their parents. Parent involvement, participation, and education was accomplished through activities such as parent meetings on subjects including child development and speech development; workshops on topics such as nutrition; and special events such as trips to the zoo and the neighborhood library. (Included is a bibliography of 47 references which usually list author, title, publisher, and publication date.) (LH)

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HOSPITAL HEAD START UNIVERSITY AFFILIATED PROGRAM FOR HANDICAPPED AND NON-HANDICAPPED

A thesis submitted in partial
fulfillment of the requirements for the degree
Master of Arts in Human Development

by

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Chapter 1

EDUCATING HANDICAPPED CHILDREN: HISTORICAL ASPECTS

The current national thrust at all levels of education is for *mainstreaming*, that is, placing handicapped children into classes with other students. Advocates contend that it is wrong to isolate handicapped children. Homogeneous grouping and tracking tend to work to their disadvantage. To segregate, separate, and classify handicapped people at any age with whatever handicaps nurtures the national ignorance and indifference. Cruickshank (1971) feels that special schools limit contact with normal peers, but that has been part of their design and purpose.

In the history of special education, the pressure and impetus for integrated schools came from organized parent groups rather than from educators (Lerner, 1071). Their idea is to change the attitude toward educating the handicapped from one of charity to one of equal opportunity.

Today twenty-nine different categories of handicaps in children are used as a basis for prescribing special education. There are few facilities, and those that do exist serve a specialized population, such as School for the Deaf, Crippled Children's Home, School for the Blind, Harbor School for the Retarded. These names for institutions have a similar sound to the ear and carry an implication that the label *insane asylum* had in the dark ages of mental illness.

Yamamoto (1972) states that the social audience determines whether certain individuals should be regarded as different by attaching degrading labels and interpretations to some facet of their being. Do such labels as blind, deaf, or retarded sum up a human being? In

essence, are not these labels stigmas? Dunn (1971) says that we must stop labeling, that the effects of disabilities label a pupil, and none of these labels are badges of distinction.

We seem to be a society bent on branding. Just consider what we do to the olive. Someone should do research into why there are ten different size classifications of the olive, each clearly stamped on the labels, yet all taste alike. This may well serve as an example of the future potential in classification of children. Children, like olives, can be sorted as midget, medium, large, extra large, huge, jumbo, colossal, super colossal. Have we done this to the sightless, the deaf, the limbless, the emotionally disturbed, and the children with all the many other disabilities that exist?

Placing more emphasis on disability rather than on ability perpetuates the rationale for special schools for the handicapped. There is the whole child, entitled to total assessment as to cognitive and emotional function to determine whether there is a real need for segregation or whether the regular classroom can integrate him. Goffman (1971) describes the feelings of self-degradation when an individual is placed in a special school. The child sees himself as a misfit in a setting for other misfits.

Rubin, Senison and Betwee (1966) found that disturbed children did as well in regular classes as in special ones.

> *Results are well-known and consistently suggest that retarded pupils make as much progress or more in regular classes as they do in special education.* (Kirk, 1964) p. 57)

Those who are opposed to mainstreaming say that handicapped children take too much of the teacher's time. Their inclusion slows down

class progress and is unfair to the normal children. MacMillan (1971) states that it is equally unfair to the handicapped child, that it is painful being called *dummy* by higher ability children. Some authorities warn that schools should be cautious before integrating the clasroom because, in the very best of circumstances, handicapped children will still need a host of support services. It has been said that two programs, special and integrated schools, to serve handicapped children are a costly duplication.

The cost of educating handicapped children exceeds the cost of educating other students, Ewald B. Nyquest, New York's Education Commissioner, said at the annual convention for the Council for Exceptional Children in April, 1974. *It can cost two to five times more.*

The Council for Exceptional Children estimates that fewer than 40% of the nation's seven million handicapped school-age children are enrolled in special education classes, 43% are school classes but receive no special training, and 17% are languishing at home settings with absolutely no schooling. These figures do not take into account nursery-age handicapped children nor the number of disabled children who are concealed from the public by their parents.

It is an impossibility to match the educational needs of handicapped children to the limited available facilities. There are very few preschool programs for them. At the elementary school level there are more resources for special education, but waiting lists exist. Even for those who are able to pay, few schools exist and fewer still for pre-kindergarten age.

There have been studies indicating that early intervention for the handicapped child and his family has resulted in successful inculcation of attitudes that result in better coping strategies. Adams (1966) said the rationale for providing services to the child is based, more importantly,

on the need of the total family unit. Rehabilitative efforts might, in some cases, be more effective if community services could begin as soon as the handicap has been identified. Services should be primarily family-centered and community-concerned. Family dysfunctions due to strain and conflict, the impact and management of the problem, and isolation are some of the reasons for early intervention (Schild, 1971).

Helping the handicapped child at an earlier age was tried by Tyson (1963). She offered a Head Start-type program for five weeks in the summer for generally immature children with pre-language retardation. She used teachers, volunteers, and speech therapists. Her success led to establishment of a similar class on a more regular basis. Kirk (1958) conducted a five year study to determine the effects of intensive education at the preschool level, ages three and four, on the rate of development of retarded children. Kirk states that significant gains were made.

Hodges, McCandless and Spicker (1967) at Indiana, Karnes (1969) at Illinois, and Weikart (1967) at his Ypsilanti Pre-School are among the few who have attempted to admit special education populations. In a five year longitudinal study, Weikart states that children initially seen as educable mentally retarded are better able to manage later school experiences after having a preschool intervention program. This is measured by a capacity to proceed through school at regular grade placement and avoid special education service or retention-in-grade (Weikart, Rogers, Adcock and McMelland, 1971).

The most favorable type of nursery school setting occurs when a few retarded children attend a regular nursery for non-retarded children (Koch and Dobson, 1971).

Integrating Handicapped Children in Head Start

The government has recently taken action to *mainstream* Head Start. (See Appendix A.) The 1972 Amendment to the Economic Opportunity Act (P.L. 92-424) called upon Head Start to increase services to severely handicapped children. (See Appendix B.) A key provision mandates that, beginning in 1973, 10% of the overall national Head Start population of 379,000 would have to be handicapped. Up to this point in the brief eight-year life of Head Start, children with handicapping conditions had been included in the program but there had been no legislative mandate for their inclusion. The government's new position was clearly defined by a more stringent definition of handicapped:

> *Mentally retarded, hard of hearing, deaf, speech impairment, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired children who, by reason thereof , require special education and related services.*
> (P.L. 92-424)

When the Senate committee compiled the new guidelines for the Amendment, it stated that minor disabilities requiring corrections would not be considered at past of the 10%.

The government's position on the inclusion of severely handicapped children met little opposition in relation to need. Poor families with preschool age handicapped children are usually ineligible for the meager resources that exist in the community, due to inaccessibility and long waiting lists. Koch and Dodson (1971) point out that children from lower socio-economic families who might profit the most find few programs available. The disadvantaged poor are subject to the same emotions and stresses as higher socio-economic families with handicapped youngsters.

Because the poor are less articulate and less powerful, they are often unable to seek out special help.(Begab, 1963). If that be the case, then Head Start must come to them. For the first time, poor pre-kindergarten handicapped children were to receive the benefits of a school experience in an integrated setting, to learn and develop with non-handicapped children.

Chapter II

STATEMENT OF THE PROBLEM

Context: Concerns of Head Start Agencies

Unquestionably, this legislation was directed towards a pressing need. However, the resultant apprehensions of the Head Start agencies was certainly understandable. Agencies were notified by the Office of Child Development (OCD) in the early spring of 1973. Immediate compliance was expected. It was difficult in the middle of a school year to adjust the enrollment to meet the 10% criterion. Agencies began to screen the current population to see how many of the children already enrolled would meet the more stringent definition of handicapped.

There was concern for the direction the government was taking in relation to the purpose of Head Start. The original concept was that it was not a *minor disability* to be poor. Head Start, by its very regulated income criteria for student eligibility, has determined that it is a pre-kindergarten educational program for the children of the poor. The government has moved away from calling Head Start a program for the *culturally deprived* to *disadvantaged* to *enrichment* to *integrated handicapped-non-handicapped*. The prognostication of some Head Start administrators is that Head Start will eventually become a *special education* program for the severely handicapped children.

There was some concern among Head Start personnel for the definition of *minor*. Ten percent of the population must have major handicaps; the implication is that the remaining 90% have minor handicaps. But is it a minor disability to be poor and from a broken home, or poor and from an

inadequate home, or poor and growing up nutritionally deprived, or poor and non-English speaking? Head Start staffs have found these conditions to be major disabilities. Working with families with these sets of handicaps is a heavy, complex workload, These conditions must continue to be recognized by the government as major problems.

The basis for the creation of Head Start was that serious life situations affect learning. Silberman (1964) comments that educational inequality plus the strain of ghetto life shunts children into classes for the mentally retarded. Children classified as educable mentally retarded (EMR) may come from environments lacking in experiences and materials, and schools cannot wait for them to catch up. MacMillan (1971) says that children who develop failure sets, i.e., who have a poor self-concept and expect to fail even before they attempt a task, are sometimes classified retarded. Non-English speaking are often considered retarded in elementary school and placed in EMR classes.

What allowance had the mandate made for teacher education? Immediate compliance without provison for special educations for the teachers? That's exactly what took place. Since the spring of 1973, Head Start teachers across the nation have been working with severely handicapped children with little or no training. One year later, in 1974, the government announced that proposals were invited to train or retrain teachers. But in that interim, 21,000 severely handicapped children were enrolled.

The Office of Child Development had reassured Head Start staff that their fears concerning inadequate time for teacher preparation were groundless. *Only a normal preschool program experience is to be provided, while agencies in the communities will provide and cope with other needs* - that was the message from OCD. It did not work out that way. During that

normal preschool program the teachers were in an abnormal position. Their lack of knowledge about disabilities and its implications proved to be handicapping classroom conditions.

The fact that a teacher has had general courses in Child Growth and Development will not spontaneously develop a realistic understanding about epilepsy, for example (Cruickshank and Johnson, 1958). Because of the pressing needs of the educational systems Barsch (1969) recommends a one-year program, ten courses of 35 hours per week, of intensive concentration on disabilities for all teachers working with handicapped children. Other educators disagree and state that two to six years should be minimum, with no less than thirty courses.

The social adjustment of disabled children at school needs teacher understanding. Yamamoto (1972) suggests that one reason seems to be that the unfamiliar disrupts the basic rules of social interaction. As a whole, behaviors of handicapped children will differ somewhat from those of the non-handicapped (Hurley, 1969). So great were the psychiatric and social problems in children who had poliomyelitis or cerebral palsy that Deaver (1956) states that the ordinary resources of a New York treatment center were ineffective. Experience seems to indicate that even if there is the best available setting, working with handicapped children is complex and strenuous.

What awareness do the teachers have of the attitudes held by the children toward their circumstances? Blackman (1968) says of primary importance is one's determination and understanding of a child's own conception of his/her capacities and limitations, experiences, and himself/herself as a person. Lord Landes and Bolles (1942) speak of a handicapped child's goals as beyond the possibility of achievement, a reality which results in negative psychological effects.

What about the human attitudes of teachers toward the crippled? Are teachers different from the general population who are fearful and avoid the physically disabled? Barker (1953) quotes Meng who, among the Freudians, think that people in general feel that someone who is maimed is evil and dangerous. How will this attitude, if present in a teacher, be interpreted by all the children? And should the disability of the handicapped child be explained to the other children and if so, how is it done?

Another aspect is one pointed out by Rosenthal and Jacobson (1966), that teachers' attitudes are affected by the label. The label reduces teacher expectancy for the disabled child to succeed. This results in the self-fulfilling prophecy syndrome (Hurley, 1969). Mussen's (1944) findings indicate that disabled persons are perceived differently in that they are expected to be self-controlled and to be conscientious. People tend to respond differently to the handicapped child, thereby increasing his or her feeling of being different from other children.

Is there a difference in the teacher's role with the parents of a handicapped child? Parents are labeled, too. The parents are referred to as *the parents of a retarded child* or *the parents of a blind child* and so on down the olive barrel. The problems of these parents have other dimensions than the problems of a non-handicapped family. In the *normal* Head Start, parent education and participation have great emphasis. The teacher is the pivotal force. *Mainstreaming* may be objected to by some members of the classroom parent body. This resistance has to be dealt with by the teaching staff. An integrated classroom adds to the teacher's responsibilities. How will he/she respond to this additional burden?

Response to the *urging* of the government to put into immediate action the inclusion of 10% severely handicapped children has been met with compliance -- by an unprepared, undertrained, underequipped Head Start. Literally, the blind are leading the blind.

Developing a Teacher Education Program in Special Education

Federation of Preschool and Community Education Centers, Inc. (F.P.C.E.C.), and agency with 41 Head Start classes in southern Los Angeles County, was faced with all these problems in the spring of 1973 when the Transmittal Notice (Office of Child Development Notice N-30-333-1, see Appendix B) of the requirement for integration of handicapped children was received. I am a Child Development Supervisor for this agency and, in anticipation of this regulation I had enrolled in a class on *Learning Disabilities* and another on *Physically Hanidcapping Conditions*. The classroom discussions, plus the recommended books, emphasized the portent and the scope of the mandate.

Teacher education was imperative. Our agency would need a crash training program fro all Head Start staff, including all nurses, social workers, nutritionists, teachers, supervisors and bus drivers, who would be involved with children. A survey of our staff indicated their involvement with continuing education, but not in the areas of special education.

A teacher can graduate from most teacher-training schools in the country without having taken a course in the areas of special education. There are not requirements in the Standard Teaching Credential to have competencies in the knowledge of handicapping conditions, identification of learning disabilities and their classroom implications. Sheffman (1970) states that educators must change the requirements and philosophies of

the teacher-training institutions. A realistic approach to the development of teacher competencies would require special education classes in the course work. If this is not possible, local school systems must provide a continuous program of in-service education. In other words, schools will need to teach not only children but also teachers (Sheffman, 1970).

We were faced with the need to teach our staff without the benefit of government resources. The limited funds made available were to provide services to the handicapped child and allowed no money for teacher training. It was at this point that I approached the University Affiliated Program (UAP) at Children's Hospital with a request that they provide a training program for F.P.C.E.C. Head Start staff. I felt that UAP could provide us with strong support in the development of a training program for working with handicapped children. UAP staff, in turn, were very much interested in becoming involved with our agency.

UAP was interested, in addition to providing a training program for our staff, in our establishing a demonstration Head Start classroom for handicapped and non-handicapped children.

Using a Community Resource: University Affiliated Program

University Affiliated Program is under the aegis of Children's Hospital. It is an adjunct of the hospital, housed in a separate building a couple of blocks from the hospital. UAP is supported by a grant from Maternal and Child Health Services, U.S. Department of Health, Education and Welfare. UAP is a training and resource center for universities and colleges. The full-time staff members represent many different disciplines: pediatrics, child psychiatry, occupational therapy, nursing, social work, physical therapy, pedontology, educational psychology,

psychology, speech, neurology and nutrition. Each of these divisions is headed by a doctor involved in teaching as well as diagnostic evaluation and treatment. Students in these varied fields at the graduate level, interns, doctoral, and post-doctoral levels, are working with UAP under the supervision of the appropriate discipline.

An inderdisciplinary approach is practiced at UAP. (See Appendix G.) At all staffings, each component is accorded respect to its input. It is advantageous to the diagnostic process to gather as much information as possible before making an assessment. Lerner (1971) mentions that in actual practice, team approaches and equal status in diagnosis are often interdisciplinary in name only. Carlson and Greenspoon (1968) point out that the team approach is defined by them as interdisciplinary clinical decision-making, which means all members sit together and work through diagnosis and treatment.

Summary

This thesis is an account of a cooperative project, sponsored by Head Start, the University Affiliated Program, and Children's Hospital, to provide a demonstration integrated handicapped-non-handicapped program for pre-kindergarten children with a built-in training component. The following chapters will describe the process of establishing a cooperative working relationship and implementing a pioneer demonstration and training program. Implications for the development of other similar programs will be discussed in the conclusion.

Chapter III

ASPECTS OF THE RELATIONSHIP

From the beginning of negotiations in the spring of 1973, final approvals had to be obtained from Children's Hospital, the funding source of Head Start (Greater Los Angeles Community Action Agency - GLACAA) (see Appendix C), and the board of our Head Start agency. This was accomplished one month prior to the starting date of September, 1973. Our agency would open a new class in the facility occupied by UAP.

The population of handicapped children for the class would be the responsibility of UAP and Children's Hospital. Referrals of handicapped children would originate from the referral center at the hospital and/or UAP. The ratio of handicapped to non-handicapped would depend on the types of disabilities and the number to be accommodated would be determined at joint staffings.

It was agreed that eligible siblings of handicapped children would be given priority in the recruitment of the non-handicapped population. Siblins of handicapped children often need remedial and enrichment programs. The remainder of the non-handicapped population would come from the neighborhood surrounding the hospital.

The doctors from UAP and Children's Hospital would do all the physicals and dental evaluations of the children. The follow-up work on physical needs would be handled by the hospitals but dental repairs would be taken care of by Head Start.

Training Needs of UAP

The primary purpose for contacting UAP was to provide training for Head Start staff and then became part of a more encomapssing plan for both Head Start and UAP. UAP had long felt the need to give their students and trainees the kind of experience that working in a demonstration classroom can provide. UAP proposed that their students be assigned to the classroom. The proximity of the classroom to the lecture hall was an additional advantage.

In addition, a separate federal grant for an innovative Health-Care Aide Training Program had been received by UAP. It was further agreed that participation in the demonstration classroom would be part of these students' field work.

An Integrated Approach to Patient Medical Evaluation

The physical proximity of the Head Start classroom was an opportunity for physicians to see the child functioning and relating in a variety of ways. Since parents participate in the classroom, this adds observable data of the child-parent-teacher-peers-school relationships for assessment. The classroom could be a *live* medical text on child development. Behaviors are quite different than in the examining room.

Doctors need more knowledge about this critical period of early childhood. Too brief are the few pages devoted to normal development in medical texts. Medicine dwells on pathology. The focus of pathology is the disease. The disease is separated out from the child, and the physician treats that, rather than seeing the this is a child -- with a disease. Fox (1960) says that doctors feel more at home when the disease has *got going*. Clinicians find the one-to-one relationship more rewarding in the responsibility for the health of their patient, rather than dealing with

the patient in his total environment (Bower, 1969). Bower further states that many parents of handicapped children are distressed by the lack of information from medical personnel regarding basic home management techniques.

Is there a doctor who has taken time to see how his patient is doing at school? Peter (1965) says that although records and forms facilitate the collection of data, nothing takes the place of personal interviews with the teacher. Has the teacher the freedom to call the doctor for information and assistance? The teacher has felt that her responsibility begins with *Good morning, children* and ends with the last goodbye.

Home, health, school -- each has its own time slot with different rival sponsors kept in their place. Cowan (1966), in the *NATURE OF PSYCHOLOGICAL-EDUCATIONAL DIAGNOSES*, speaks to the point that a physician looks at what is bodily wrong with the child, labeling and hoping for a remedy, disregarding the involvement of the patient's interaction with the environment. Hopefully, this hospital-based demonstration classroom could be utilized to make a dent in this tradition. By providing an on-site training situation for students and continued training for UAP and hospital professionals, UAP was responsible for breaking away from the clinic or office visit approach to doctor-patient relationships. A Head Start classroom in this setting obviously would be serving a variety of needs, all dedicated to the best interests of children.

Summary

I have been unable to find a comparable Head Start program with a hospital affiliation anywhere in the nation. There is a clinic at the University of California in San Francisco for children between the ages of five and sixteen years, for individual or small group learning with an

interdisciplinary approach to diagnoses. There, after a team evaluation, the child reports to the clinic two or three times per week for individual or small group learning. Conclusions drawn from participants and observers in this San Francisco program are that the hospital environment has many advantages for medical personnel, clinical teachers, the child, the family and the community. Medical students, interns, and residents help in the diagnosis, communicate freely with teachers, and they become aware of problems in the classroom. Parent and child receive a better understanding of the problems by a medical setting. The advantage to the community is a facility for training all personnel (Whitsell and Whitsell, 1968).

These were the hopes of Head Start and UAP and Children's Hospital for the hospital-based demonstration classroom that opened in September 1973. The following chapter describes the operational structure and costs.

Chapter IV

OPERATIONAL STRUCTURE

Selection of Staff

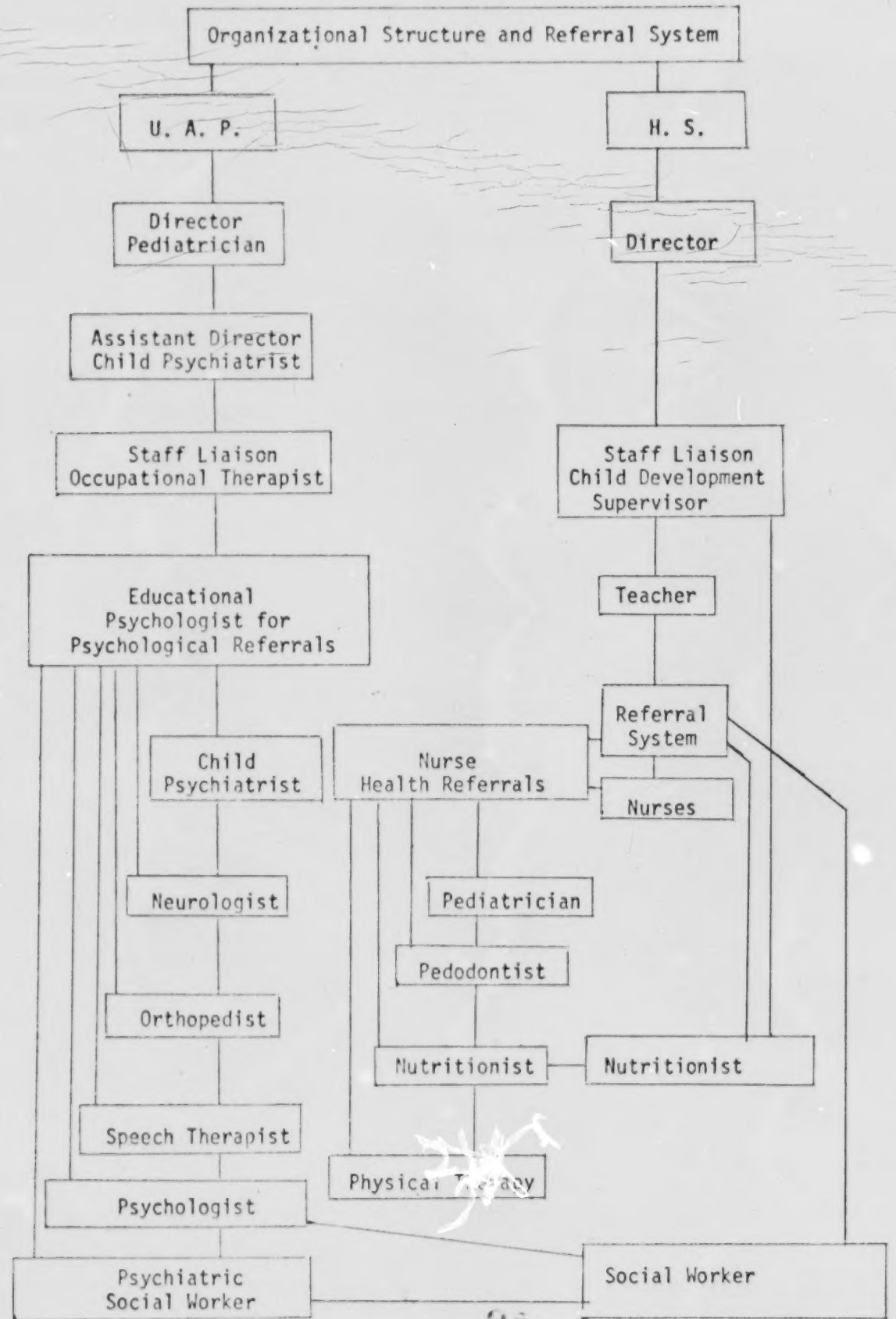
Selection of teachers remained the responsibility of Head Start. The choice of teachers was difficult. The F.P.C.E.C. Agency board members felt that teachers within the Head Start Program should be given the opportunity to work in this special program. Whereas none had worked with handicapped children or had special education coursework, they did know the educational model used by the agency, the Head Start population, and the requirements of the agency. The selection of the teaching team was made from recommendations of the different supervisors on the basis of high teacher performance, ability to handle stressful situations, and skills in relating to co-workers. The teacher and the assistant selected proved to be excellent choices. They considered it an opportunity to learn and were proud of the distinction of being chosen.

Hours

Negotiation over class hours was required. UAP preferred a late beginning time in order to accommodate the professional students observing and working in the classroom. However, in the best interests of the children, UAP agreed to the 9:00 am to 12:30 pm class day.

Operational Structure

The teachers had to relate to two staffs, UAP and Head Start. The organizational structure (see page 19) of UAP had some of the same counterparts as Head Start. A group of volunteers from the UAP staff elected to


Organizational Structure and Referral System
U. A. P.
H. S.
Director Pediatrician
Director
Assistant Director Child Psychiatrist
Staff Liaison Occupational Therapist
Staff Liaison Child Development Supervisor
Educational Psychologist for Psychological Referrals
Teacher
Referral System
Child Psychiatrist
Nurse Health Referrals
Nurses
Neurologist
Pediatrician
Pedodontist
Orthopedist
Nutritionist
Nutritionist
Speech Therapist
Physical Therapy
Psychologist
Social Worker
Psychiatric Social Worker

work as a Head Start committee with the Occupational Therapist as Liaison chairperson. All the problems related to the program were to be channelled to the Occupational Therapist. The Educational Psychologist agreed to process all psychological referrals. The UAP head of nursing would process all health care needs, the follow-up work, and assign all students to the classroom from all the disciplines in consultation with the Head Start teaching staff. I acted as liaison person between UAP and Head Start and coordinated all Head Start support services.

This structure was requested by UAP in order that one person in each agency would be knowledgeable and responsible for the delivery of services and the state of progress of those services.

Record-Keeping

Record-keeping was voluminous. Each agency had its own set of procedures, forms and monthly statistic reports. Head Start staff had to duplicate information on UAP forms.

There were enrollment and health forms, monthly attendance, nutritional intake recording, volunteer time records, and progress reports. Anecdotal records were kept on each child. There was a constant flow of referral forms and inter-agency memos. Parent meetings content was documented.

Costs

In order for F.P.C.E.C. Head Start to proceed with final arrangements, the last step was to obtain permission from the funding source, GLACAA, to relocate one of the agency's classes in a geographical area outside present boundaries. Relocation was necessary as there were no available monies to operate an additional class. Permission was received. The

funding source had received an additional $55,000 to implement services for the 10% handicapped enrollment. After deducting funding source operational costs, $41,052 would be available to 373 handicapped children. Each agency would be allowed $110 per child that was *certified* handicapped. Certification meant that an attending physician had to attest to the disability.

Our agency would give UAP $110 for services to each handicapped child. Later in the school year, some of the other agencies followed our lead and arranged for UAP to do diagnostic work-ups of referrals of their handicapped children.

The government requires that Head Start must have 20% in-kind contribution. There is the equivalency of a sliding monetary scale for services of volunteers, ranging from a base of $2.00 per hour and increasing in rate according to skills. No actual money is paid. It is a paper transaction. Each person who contributes his/her services or material goods signs a donation form. The number of volunteer hours is totaled and translated into a dollar figure on monthly recap sheets.

A regular Head Start class averages from $200-$500 per month in volunteer services. The Children's Hospital Head Start averages from $2000-$3500 monthly. This serves as an indicator as to the amount of involvement of parents, UAP staff, students and community volunteers.

Summary

The development of this program was difficult because of the involvement of so many agencies. The development of a cooperative relationship among agencies is complicated, but, in our experience, well worth the effort.

The training component of our Head Start-UAP program was planned in two parts: Head Start staff training, which was our original reason for seeking the affiliation, and use by UAP of the special resources this program provided its participants. In the following chapter both of these training aspects are described.

Chapter V

TRAINING COMPONENT

Head Start Training Proposal

At a meeting of the assistant director and staff liaison person and me as representative of our agency, the need for Head Start staff development was discussed. As a result of this preliminary meeting, the two staff liaison persons from each agency devised a proposal. (See Appendix E.)

The primary objectives agreed upon for the proposed UAP training program for all Head Start staff components were:

-to recognize that a child may be handicapped

-to facilitate treatment through early identification and diagnosis

-to assist all Head Start staff components in developing skills need to work with handicapped children and their families.

The Training Program: Seminar Approach

These objectives were to be accomplished by in-service education through a variety of ways. UAP made available to Head Start staff the following training activities held for their professionals and students from the various universities:

-Interdisciplinary Seminar Series

-Feeding Course and Clinic

-Interdisciplinary Patient and Case Conferences

-*Mini-Seminar* Special Content Seminars

-library materials

Each Head Start supervisor from the different components, i.e., child development, social work, nutrition, nursing, and parent education, selected from the list of topics to be discussed at the seminars those areas of interest related to the component. The number of Head Start staff allowed to attend the seminars depended on the space factor of the lecture hall at UAP, the time of the lecture, and the replacement of teachers with substitutes. Assistant teachers could be replaced by a parent, according to budget regulations, but teachers had to be replaced by paid substitutes which created a budget problem. When the seminars were held after Head Start classroom hours, the teachers and the assistants were able to attend without all the involved rescheduling.

Two special seminars co-sponsored by UAP and the University of Southern California were made available to Head Start staff. One was the Fourth Special Invitational Interdisciplinary Seminar on Piagetian Theory and Its Implications for the Helping Professions held in February, 1974; the other was a Movie Marathon on Handicapping Conditions held in the spring at the University.

The four special seminars, as specified in the proposal, directed specifically to the Head Start staff, were conducted by UAP. The four major areas included:

1) classroom techniques in working with handicapped children
2) information regarding handicapping conditions
3) knowledge and skills in working with parents and families of the handicapped child
4) staff attitudes toward the handicapped child

Head Start Teacher Training via Classroom Observation

Teachers and assistant teachers were released throughout the year to observe the Children's Head Start class. The observation helps teachers to gain a perspective regarding activities and achievements of all children, handicapped and non-handicapped. Specific ways in dealing with specific disabilities were observable and, in some cases, the learning was transferable.

Children's Hospital Head Start Teacher Training

The teacher and the assistant teacher selected for placement at Children's had no special training in working with handicapped children. On September 10, 11, and 12 in 1973, before the classroom opened I heard about a training workshop that was to be held in Palm Springs sponsored by the San Diego Head Start Cluster of Grantee Agencies. Although the Los Angeles Grantee, the funding source, GLACAA, was not part of this group, the program developer for the workshop was the Head Start Regional Resource and Training Center at the University of Redlands who gave permission for me and the two teachers to attend. This workshop served as an intorductory course. Two of the speakers were from UAP. (See Appendix F.)

There were two follow-up one-day meetings held in January and May, 1974, at Children's Hospital Auditorium in Los Angeles. Since UAP developed the program for these meetings 40 or our Head Start staff were invited to attend. At the meeting in May, the head teacher of the Children's Head start was invited to speak.

UAP Staff and Student Training

As an introduction to Head Start, its function and purpose, all UAP staff and students were invited to a luncheon held at UAP in early October. Over 150 people attended. This provided the opportunity for each discipline in Head Start to explain what services were offered to families, how the service was accomplished, and why it was necessary. This meeting generated much enthusiasm and interest in the Head Start program. The next day donations of services were offered and donations of clothing and furniture filled the classroom.

Training of UAP Students via Classroom Participation

Students were assigned on a regular weekly basis for each semester to particpate in the classroom experience. They were directly involved with the children and the parents. They met with the teachers prior to the children's arrival in the morning and had an opportunity to discuss with the teachers the activities and child behavior after class.

Summary

The training program was a strong beginning to meet the needs of Head Start to develop staff abilities in working with the handicapped child and family. The classroom provided UAP with a training model for their students and professional staff. The following chapter describes the program in action..

Chapter VI

PROGRAM

Space and Equipment

The room that had been designated in the UAP building was compact, pleasant, and sunny with double exposure windows. It had a large storage closet and two exits, one leading out to a grassy play area shaded by trees, and the other into the hallway of the building. The yard was enclosed by fencing with a driveway running along the far side. The UAP staff voted to keep the gate closed during school hours although it limited their parking facilities.

Special equipment for handicapped children has been recommended by the occupational therapist, the physical therapist, and the speech pathologist. Such items as tables with cutouts for wheel chairs, sturdy straight-seated wooden chairs, square skate boards, tumbling mats, a sand table on legs, and oversize manipulative table toys (to encourage muscle use and development) were purchased in addition to regular equipment by Head Start.

Audio-visual equipment was installed by AUP. A one-way mirror replaced the pane of glass in the hallway door. The classroom was provided with a tape recorder, record player, camera, and a language master.

Educational Model

The F.P.C.E.C. Head Start had been using the Responsive Model designed by Glen Nimnicht in association with the Far West Laboratory in San Francisco. It is used in various educational systems across the

nation. It is basically a child-centered curriculum based on Piagetian and Montessori theories, as well as the work of Deutsch and Omar Khayyam Moore. The model is considered to be autotelic (engaging in activity for its own sake). The environment is described as follows:

1. It permits learner to explore freely.
2. It informs learner immediately about the consequence of his/her action.
3. It is self-pacing -- rate determined by learner.
4. It permits learner to make full use of his capacity for discovery relationship of various kinds.
5. It is structured so learner is likely to make a series of interconnected discoveries about physical, cultural and social world (O.K. Moore, 1964).

As for the Montessori ingredients, many of the classroom materials were self-pacing and sequentially paced. Kirk (1958) conducted a 5-year study to determine the effects of intensive education at preschool level (3-4 years), using Montessori methods, on the rate of development of retarded children. Significant growth was measured. In Montessori materials all but the essential quality is ruled out. This isolation of stimulus is less confusing to deal with for the retarded child. Mink (1964) feels that the multi-sensory approach is very helpful.

Although the Responsive Model appeared to cause little frustration to the handicapped child, Weikart, in his research, demonstrated that educational models make little difference as to the superiority of one over another. His Curriculum Demonstration Project used three models with handicapped and non-handicapped children: Bereiter and Englemann, Piaget cognitively-oriented, and a child-centered model. There were no significant differences among the three curricula. All showed significant

gain. Weikart states *that no specific curriculum has the corner on effective stimuli* (1971, p. 10).

UAP Contributions to Planning and Curriculum

The resources of UAP made it possible to supplement the basic curriculum with psychotherapeutic and medical elements. The classroom served as a psychotherapeutic release for stress symptoms in children:

> Robert was confined at home to a small area in an apartment and not allowed to play outside. His mother was ill with cancer and was unable to cope with an active four year old. He was her only child and was born when she was in her early forties. Robert was referred to the class by Children's Hospital. His behavior was described as hyperkinetic and his speech echolalic. He was literally tied up in knots. School provided an outlet with its space and the freedom to use it. At first, he was always in motion, running from area to area, perspiring freely. By the middle of the school year his behavior was modified and by the end of the year it was predicted that he would be able to cope in a kindergarten setting. It was as though his development had become stalled and school and medical support had put him back on the developmental track. Eridson (1964) says that the school situation can be used therapeutically to release stress. It worked for Robert.

> Sharon was another child who was referred because of emotional problems. She continually shouted any and all communications. Her hearing tested normal. Observation of the mother-child relationship indicated that the mother was soft-spoken but never responded unless Sharon screamed for attention. The mother was encouraged to respond promptly to her daughter and eventually the shouting was phased out. It becomes quite clear that children develop coping strategies to try to have their needs met (Murphy, 1962).

The UAP and hospital staff and students added curriculum. Before the children were scheduled for physicals, the whitecoated pediatric fellow became familiar to the children in their play environment. After many drop-in visits, he invited them to his examining room where he introduced the equipment he would use. The children became the doctors and tried out the doctor's stethoscope on each other.

The psychiatrist did classroom observations. He would drop by informally to discuss problems with the teachers.

All members of the UAP staff would drop in frequently to visit. The children and parents took a conducted tour of Children's Hospital as a field trip. (See Appendix J.) The clerical staff had treats on their desks at Halloween. The doctors vied as to who would be Santa Claus. Presents for each child were provided by the Auxiliary at the Hospital.

The maintenance crew dug up a plot of ground for a vegetable garden. It was planted by the children and produced enough for several mixed-green salads.

Planning was the most essential phase of the program -- planning for individual children, for students, parents, medical care, volunteers, Head Start staff. Because of the high ratio of adults in the classroom daily, a traffic pattern had to be developed. Over 50 students worked in the classroom during the nine months. In order for the students' assigned time in the classroom to be meaningful, opportunities had to be made for direct teaching experiences. For example, the nutrition interns brought in assorted fresh vegetables and managed a table activity of vegetable figure sculptures. The health care aide student spoke Spanish and helped in assessing language problems of Spanish-speaking children.

Staffings (Case Conferences)

Staffings on individual children were held both for admission of handicapped children and for on-going planning. In these meetings we discovered that the ideal of equal status among the representatives of each discipline does characterize interactions at UAP. The students who observed and worked in the Head Start classroom, the attending doctors, and representatives of the various disciplines all contributed their perspectives

and data to the case of the family being discussed. The counterpart staff of Head Start, i.e., nurse, nutritionist, social worker, teachers, and child development supervisor also participated. When there were other agencies involved, their representatives attended and added their data. Then a determination would be made as to which agency would take the lead and what would be the course of action.

The staffing would cover such areas as the child and the parents' overt behavior, interpretation of the behavior, family history and present situation, classroom progress and social relationships, health history, feeding problems, personality strengths and weaknesses. All these factors were checked and doublechecked. From this diagnostic evaluation or, in newer terminology, *assessment* came recommendations as to management of behaviors, individual and/or family counseling, play therapy, health care, employment, dependent on the problems of the individual case. But, most importantly, the family structure was the first concern. These sessions were valuable learning for all present.

Child Population - Head Start Criteria

Head Start has regulations for eligibility to the program; one is income criterion (see Appendix E) and an age criterion (3 years, 9 months to 5 years) that have to be observed. Other conditions are the number of children (15 per classroom), with teacher, assistant teacher, and a parent and/or community volunteer.

The UAP building, in which the classroom was located, appeared to be in a low-income community. Head Start tries to locate classes within walking distance of homes. As bus transportation was unavailable there was a concern whether there was a sufficient non-handicapped population in the

neighborhood. After going from house to house and finding the age requirements a barrier and families just over the income criteria, the teachers were able to fill the class by recruiting in front of a neighborhood market.

The ratio of handicapped to non-handicapped was not determined at the outset. The ratio would be determined by the types of disabilities and what the disability involved. Each handicapped referral was discussed at a joint staffing before acceptance in the classroom.

Enrollment

By November enrollment of 15 children was completed. Three families were on welfare and rest low-income. The ratio was six handicapped and nine non-handicapped. There were eight boys and seven girls, with two girls and four boys *certified handicapped*, in government terminology. Although the chronological ages were 3 years, 9 months to 5 years, the functioning ages were 30 months to 5 years.

The classroom population had a one-world aspect, truly multicultural (see table on page 34). This diversity enriched children's learning from children. Both handicapped and non-handicapped shared common experiences. They quickly came to appreciate the limitations and capacities of each other. I get visual images of Rosannah trying to teach Danny to say a work, or Rudy showing Robert that trike riding is fun and not scary.

By the end of the school year, all the children with the exception of two Spanish-speaking children, spoke English. These two preferred to speak in Spanish. English was taught as a second language whenever possible. This was accomplished through the parents and the fluency of the UAP students. The non-English speaking Chinese and Korean children

TABLE 1

Enrollment in Demonstration Classroom, October 1973

Sex	(by government definition) Handicapped	Ethnicity	Child's Language	Mother Speaks English	Entry age
M	no	Filipino	Tagalog	yes	3 yr., 11 mo.
F	congenital amputee	Mexican/ American	Spanish	some	4 yr., 8 mo.
F	no	Chinese/ Japanese	Chinese	yes	4 yr., 5 mo.
M	mental retardation	Mexican/ Black	None-- English	yes	4 yr., 11 mo.
F	emotional	Mexican/ American	Spanish	yes	4 yr., 6 mo.
F	no	Mexican/ American	Spanish	no	4 yr.
M	no	Mexican/ American	Spanish	some	4 yr.
M	hyperactivity echolalia	Caucasian	English	yes	4 yr., 8 mo.
F	no	Mexican/ American	Spanish	no	4 yr., 6 mo.
M	severe asthmatic	Black	English	yes	4 yr., 3 mo.
M	speech emotional	Caucasian	English (minimal)	no	5 yr., 1 mo.
F	no	Korean	Korean	no	4 yr., 5 mo.
F	no	Black/ Caucasian	English	yes	4 yr.
M	no	Mexican/ American	Spanish/ English	yes	4 yr.
M	no	Mexican/ American	Spanish	some	3 yr., 10 mo.

(continued on next page)

TABLE 1 (cont.)

Sex	(by government definition) Handicapped	Ethnicity	Child's Language	Mother Speaks English	Entry age
*F	yes	Caucasion	minimal	yes	
**F	no	Mexican/ American	Spanish	yes	3 yr., 10 mo.

* Guest, no room for official enrollment

**Request of speech therapist to allow child (under age) and mother to visit twice per week. Average daily attendance was thirteen, therefore accommodation could be made.

were forced to move into English quickly, as translators were not available.

Working with Individual Children

The teachers tried to assess how much each child could learn, under what circumstances, and with what materials. Methods of handling affective behaviors were varied. Sometimes firm control for the uninhibited child, or for the hyperactive when hitting was involved, and more permissive treatment for the withdrawn, apathetic youngster were prescribed.

Special education diagnosis is highly clinical, yet intuitive. The teachers concentrated on success. They understood the impact of feelings of success, failure, and frustration. Praise was used generously with all children. Some extrinsic rewards as reinforcers were given in the beginning. The attractive environment was welcoming and the staff enthusiastic; few limits were necessary. Children had choices and were able

to pursue their own interests, helped when necessary to try new activities.

As an example, Danny was phobic about getting a speck of anything on his hands. The children mixed the play dough, wet the clay, fingerpainted, and other messy activities. The teacher would engage in an activity and demonstrate over and over again how she was able to wash her hands clean again. Fortunately, there was no language barrier - that is, in relation to his culture. Both of his parents spoke English; although Danny understood what was said, he was unable to speak. Danny continued to stand back and watch the activities. By the middle of the year, Danny was sticking one finger in the flour bowl and by the end of the year, he was up to his wrists in finger paint. He was constantly reinforced with praise and applause from the teachers and the children. Patricia, a Spanish-speaking child, took Danny as her friend and went about encouraging him (in Spanish which he did not understand) to join in activities.

Two Boys

Below is a capsule comparative of a handicapped and non-handicapped child.

RUDY (Non-Handicapped)	MICHAEL (Handicapped)
Four years old	Five years old
Stocky build	Lanky
Mexican American	Causcasian
Neighborhood child	Referred by Children's Hospital
Older brother: 7 years old, handicapped, bone cancer	Older brother: 7 years old, handicapped, retarded
Mother and stepfather in home, marital discord	Mother and father in home until January when mother filed for divorce
Fluent in Spanish and English	Minimal verbal communication

Capsule Comparative (cont.)

RUDY	MICHAEL
Mother volunteered in classroom weekly until brother became an invalid	Mother volunteered in class daily because of severe separation problems (elementary school kindergarten unable to cope with problem)
No separation problems from the beginning	Separation time steadily increased until completed in November
Health good	Diseased tonsils: constant nasal congestion until Children's Hospital arranged for tonsillectomy in April
Family income seemed steady	Mother employed
Adult supervision	Child left unattended
Leader in group, relates well to adults	Shy with children and adults
Self-confident, explores all activities	Preferred sedentary activities in beginning
	Speech therapy in spring
	By June, looked healthier, gained weight, mother/child appeared happier

Most Severely Handicapped Child: Capsule History of Danny

Danny was referred by Children's Hospital. At 4 years, 11 months of age, he was functioning developmentally around 30 months. He was the first enrollee. The family lived a 45-minute drive away from the school. He had an aunt in the neighborhood and his father drove them there before going to work. The mother, Mexican-American, had remarried when Danny was 3 years old. Danny's real father had been placed in jail for a second offense of child cruelty. At 6 months of age, Danny had been thrown against a wall by his father.

The child was placed in a series of foster homes due to difficulty in his management. There is an older sister living somewhere else. The

mother claims no one would tell her where he was and she did not find him until he was three years old.

Danny wears diapers, eats no solid foods, is bottle-fed, cannot talk other than a faint sing-song.

The mother's self-esteem appeared to be damaged by her aunt and her husband's frequent threats of divorce. The mother seemed retarded. Therapy was recommended and she accepted with delight. She never missed an appointment. Her appearance improved and a weight loss occurred. She looked younger. The psychologist's diagnosis was psychosis.

The child attended speech therapy. The teachers decided to make some demands on him in relation to language, and what evolved were the few words that he speaks. He can now say a few words, all related to what he wants, such as *coat*, which means he wants to go outside, and *skateboard*, which he has mastered. He joins in humming some of the songs now. The teachers and the children have encouraged him to try foods. He can drink from a cup and will make chewing motions with the children, tasting some things.

The mother refuses to accept the word *retarded* and became quite angry at the psychologist when he used that term for Danny. She says he is *stubborn*.

It takes a series of sessions, spread out, before most parents come even somewhat to grips with the nature, and particularly with the implications, of a diagnosis (Wolfensberger, 1971).

The father *gives him a slap* for his *stubbornness*. The mother gives daily exaggerated reports to the teachers of Danny's new accomplishments, none of which is validated at achool. Although the teachers have worked with her to allow Danny responsibility and to try other feeding solutions,

she will still give him his bottle in the parking lot as they are departing.

Rosewell and Natchez report that parents refuse to accept or become alarmed at a child's inability to learn. The parents refer to the child as *plain lazy* or *stubborn* (1964).

Many agencies were involved in Danny's case (see Appendix I) and due to the intervention of Head Start there is now consolidation, with one agency taking the responsiblity of the family in the future.

Parents-Classroom Participation

There were several components to parent involvement and contact. The following pages will discuss the various aspects. The most important, as far as Head Start operates, is classroom participation by a parent or a member of the family. On a purely practical basis, it is easier to individualize an educational program when there are more resource people around for the children. All the mothers participated in the classroom in the beginning of the program. Two fathers were able to work in the classroom or join on field trips. Father participation was difficult as all were employed, either on jobs or in babysitting while the mother worked. There were fathers in all homes but two. One divorce occurred midyear.

Three mothers found employment during the year and were unable to continue in the classroom. Another had to remain home due to a handicapped older child. Four mothers were pregnant and continued to participate to the day of delivery; they returned in two weeks, bringing the newborn along.

In the classroom each parent worked as a teacher. In the Mexican-American culture, much respect is given to the *maestra* (teacher). When

the parent modelled the teacher role, her sense of pride was apparent.

Many of the parents were needed as interpreters for the children and the parents. The class functioned better when they were there and they knew it. That may account for the number who wanted to participate daily. Four to five mothers and the younger siblings joined the class daily. Though reluctant to discourage their attendance, the teachers had to limit the number of two. The ratio of adults, because of the students and mothers, practically became one adult for each child.

The teacher, working alongside the parent, was able to interpret behavior objectively and explain classroom techniques and procedures. The parent was learning and teaching on the workday.

Parent expectations are comparative rather than cumulative (Felsenthal, 1972). The teachers gave day-to-day feedback to the parents. Mothers were given homework. It could be a book to read to the child or a puzzle. On a home visit, the teacher demonstrated to the parent how much stimulus and opportunities the home offered. This method of Home Start was used in two cases.

One of the significant differences between a regular Head Start class and this model was the markedly increased amount of time needed by the parents for talking over problems related to their child and their personal life. A sympathetic non-judgmental teacher can effectively help most parents in dealing with the feelings evoked by their children. The teachers had to recognize what was in their province and when other professional help was indicated. The parents trusted the environment and were made aware of all the services available to them.

Parent Meetings

Every Head Start class forms a parent organization. The parents of

of the Children's Hospital Head Start were no exception. In the beginning of the school year the parents were invited to a meeting to begin the process of forming their own organization. By the third meeting, the parents were ready to elect their officers. The president-elect was bilingual. Although at first she was dependent on the teachers for guidance, in a short time she developed self-confidence and became an effective leader.

In our agency there are 41 parent groups and each send representatives to an Agency Parent Council monthly meeting. There, total agency policies are decided by the representatives. Children's Head Start was a considerable distance from the central office where the meetings were held. Transportation was provided to the representatives so they could attend and feel part of a network of schools or classes. They learned that they had a voice in policy-making decisions.

Sexton (1961) says that no school system is doing nearly enough to educate impoverished parents to the necessity of involvement in school affairs and to share influence over policy. But Head Start has demonstrated its success in the area of parent involvement, parent power, and parent education. Hurley (1969) says that educational prospects appear dim if the process of bringing poor parents back to involvement in the school system is not accomplished soon. Head Start has encouraged parents to continue their involvement by bridging public schools through visitations and on-going dialogue with school administrators.

Parents' meetings at Head Start schools are usually held twice per month. At Children's Head Start, the meetings were held weekly until January and then twice per month. After the officers were elected from the attending parents at one of the early meetings, the Head Start staff,

teachers, social worker, and I, as child development supervisor, discussed with the parents their preferences for educational topics available for parent meetings. With the readily available resouces of UAP a greater number of options were available. Translation from English into Spanish of the discussions was done simultaneously; although this method slowed sown the progress of a meeting, it also held the attention of the group.

The cohesiveness of this parent group was striking. Whether it was due to the weekly parent meeting format in the beginning which enabled parents more frequent contact, or to the composition of handicapped and non-handicapped, or perhaps to the affiliation with the hospital and UAP that provided another dimension to Head Start -- whatever was the cause, the effect was measurable by the sustained parent attendance, involvement, and the number of friendships among the parents that developed.

Parent Activities

The following lists some of the activities that involved the parent group during the school year.

Parent Meetings

-Introduction of Head Start staff and support services and their functions

-Educational model and classroom procedures

-Election of officers - description of duties

-*All About Children*, a series of three discussions led by child development supervisor. Contents: *What to expect from a preschooler, Children's fears, Parents' concerns.*

-Speech development - UAP speech therapist

-Child development, a series of six discussions led by two UAP psychological interns.

-Nutrition - Head Start nutrition supervisor

-Preventative dentistry and dental hygiene - pedontist, Chief of Dentistry at Children's Hospital

-Home and self-protection - Los Angeles Police Department

Workshops

-Christmas: low cost gifts and decorations; Pinata making - Head Start social work aide

-English lessons - community volunteer

-Cooking classes, a series of six - UAP nutrition interns

-Needlepoint - UAP staff member

Special Events

-Mothers going as a group to get TB test

-Halloween party

-Christmas dinner and party

-Trip to the zoo

-Tour of Children's Hospital

-Picnic at the beach

-Visiting neighborhood library

-Observing the kindergarten class their child would attend

Parent Meetings as Group Therapy

Some of the mothers' discussions about their children in parent meetings seemed to be therapy sessions. Cooley (1922) says that parents often report that their contacts with others have helped them with their own feelings, that sharing feelings gives them emotional support, comfort, and the opportunity for realistic appraisal of their child's possibilities. Coe (1967) states that parent organizations provide the best meeting grounds for the parent and the professional.

The blending of mothers of handicapped and non-handicapped presented no real problem. However, one mother had difficulty being accepted or

accepting the group. She was in her forties, Caucasian and a college graduate. She had been a secretary and she told how it took her ten years to get a B.A. by attending night school. She talked down to the Mexican-American mothers and they were hurt by her bigotry and snobbishness. But at one of the earlier parent meetings, she asked, *Will my son remember me?* Parents were stunned to learn what the staff already knew -- she had terminal cancer. After that the parents treated her gently, ignoring her bigoted remarks.

She was a handicapped parent with a handicapped child. Cruickshank and Johnson (1958) say that in the presence of a handicapped child, frustrations are bound to arise. How difficult it must be for her, to have to handle her problem as well as her son's. This mother treated her son harshly. Perhaps in this way she was preparing for the separation, as if he did not matter.

The group meetings helped the parents of the handicapped children. Koch and Dobson (1971) say that nursery schools can bring parents of handicapped children together, learning that other people have the same problem helps to lighten the load. Events come into better focus. With the exception of the one mother who had come from a higher socio-economic status, the rest of the parents of the handicapped children were from chronic poverty. Farber (1960) explains that mothers with higher socio-economic status are found to respond to the diagnosis of a handicapping factor in their child as if to a bereavement, whereas mothers from low socio-economic status were found to respond to the same information as a family crisis.

Parents as an Extended Family

Parents got to know one another very well. The group became an extended family, carpooling, babysitting for each other, visiting at homes. Some of the mothers had lived quite an insular life because of their culture or responsibilities at home. One mother said she enjoyed the sociability of the school so much she was afraid if she told her husband he would not allow her to come any more. Another mother responded by revealing that her husband said she had to return home the minute school was out.

Much ado was made over the new babies. Four babies were born in January. The teacher had asked the parents to keep notes on what they did to prepare their other children for the new baby. The letter which follows below is from one of the mothers.

Parents learned that they can learn and that their children can learn. This change in attitude might prove to be a significant factor to provide an environment that gives an incentive to keep learning.

Letter

Preparing Jonathan for the Baby

Sibling rivalry has been our main concern when we decided to have another baby. With this in mind then, we made every effort to prepare Jonathan for the coming of the baby. We took every opportunity to expose him to babies and let him cuddle them and asking him if he liked one of our own. We did everything to assure him that we love him - whisper endearing words to him even in his sleep, letting him sleep with us (a practice common to Filipinos), play with him.

All during the course of my pregnancy, I try to involve him in preparing and buying the layette, giving me my medicine (vitamins)

explaining to him the purpose for it (so our baby will come out healthy and strong). When there were discernible fetal movements, we let him feel it and hear through the stethoscope when I go for prenatal check-up. We ask him to take care of the baby when the time comes.

When I went to the hospital we told him where I was going - and what I was going to do. The following day, he came for a visit and we went to the nursery to see our baby. He stayed there for some time looking at it and during my stay in the hospital, he came repeatedly for visits and always, he passed by the nursery to see our baby.

When we returned home, he was with us to take the baby home. We let him help in little ways like giving us the diaper, pins, powder or whatever the baby needed. During all these times we avoided shoving him or getting him away from the baby but instead showed him the right way to handle the baby - stroking her in the arms or legs. We also let him help hold the feeding bottle.

Jonathan continued to sleep with us and when we held the baby and ask for him to be held, too, we tried our best to hold them both - of course even just by putting our arms around him too. When we kiss the baby we kiss him too. We avoided reprimanding him when he did something wrong but instead showed him how things are done. We continued with this treatment and up to the present we still do cuddle him once in a while, let him sleep with us and help in everyway he can. So far, he has not hurt the baby intentionally or showed jealousy. We hope it stays that way till they both grow to be man and woman.

Chapter VII

CONCLUSIONS AND IMPLICATIONS

A Head Start classroom for handicapped and non-handicapped children, located in a training hospital setting, is an advantageous relationship. This type of three-way affiliation - UAP, Children's Hospital, and Head Start - a medico-psycho-social-teaching team, can offer extensive services to families and to the community. As far as I have been able to discover no similar project exists elsewhere; therefore, for the first time in a single setting, a preschool program offers to low socio-economic families of both handicapped and non-handicapped children, at no cost, a combination of comprehensive health care and educational programs.

Each sponsor has made a unique and significant contribution and has received a supplementary service. Children's Hospital offers complete health services and now has a Head Start school to which to refer preschool handicapped children. With the close relationship to the classroom, hospital personnel can gather observable information for additional diagnostic evaluation.

UAP, as the immediate referral center for the Head Start families, offers an interdisciplinary approach for assessment and planning. It provided an in-service education program for Head Start staff. An early childhood observation class for its students from other institutions is a convenient, appropriate adjunct. The instructors are able to validate the students' observations and give immediate feedback. Since the range of children's abilities and disabilities, similarities and differences,

and their effects on growth and development are so varied, the classroom provides an unusual opportunity for learning.

In this setting, Head Start can offer families comprehensive health care that would not be readily available in other Head Start or pre-kindergarten programs. To comply with the federal mandate and provide expert care has been accomplished in this school due to the support and *overseer* role of UAP. The F.P.C.E.C. Head Start staff has been in an enviable position due to the affiliation with UAP. The observation classroom, with two teachers-in-training, the in-service education, the staffings, has offered the agency's staff a head start in learning about special education.

Implications of Co-Education (UAP Staff and Head Start Staff)

The exposure of the somewhat ivory-tower, teacher-clinicians of UAP staff to the earthy, no-protocol qualities of Head Start resulted in their bumping against each other somewhat abrasively at times, but the impact was healthy. In several aspects of the relationship this occurred. Head Start has an *intensive care* approach, ten months to work with a family to hopefully resolve some of the problems. One does not sense any of that imperative *Now!* at UAP. Medical staff develop a *keep-at-a-distance* attitude, probably for self-preservation. The classroom teachers and Head Start support services, child development supervisor, nurse, and social worker, work together to see if the essentials of life can be provided if missing, i.e., food, jobs, clothing, transportation. UAP has a different starting base.

At seminars, Head Start staff would deviate from the agenda with social problems such as hospital's lack of provisions for translators

and *indifference* to that need, for not reaching out into communities with services, discriminatory hiring practices, no speech assessment for non-English speaking children. There was more than one occasion where the instructor was speechless when confronted with the anger and indignation of the more militant Head Start personnel.

Both Head Start and UAP suffer from politics, funding cutbacks, procedures, clearances, all get in the way of speedy delivery of services. Attitudinal changes, by both staffs, took place through the exchange of viewpoints. The program was the vehicle providing counterpoint learning.

Evaluation Meeting

On May 28th, 1974, a meeting took place which had long been arranged, for the program directors and staff of Head Start and UAP to come together for an evaluation of the program. Attending UAP staff included the following: director-pediatrician, assistant director-psychiatrist, staff liaison person-occupational therapist, nurse, nutritionist, psychologist, and the educational psychologist.

Head Start representative were the director, staff liaison-child development supervisor, nurse, social worker, teacher, and assistant teacher.

The Director of UAP chaired the meeting and drew a chart on the chalkboard to note the positive aspects and problems of the activities of the year. Everyone participated in the discussion. See Appendix H for a summary of the findings.

Two weeks after the evaluation, the UAP staff met to decide whether to continue the Head Start program for the year 1974-1975. When notified of the decision to continue with the program, Head Start staff were re-

delighted. The only change would be the assumption of the UAP liaison role by the assistant director, the child psychiatrist.

Training Component

It was a broadening experience for Head Start staff to learn about Children's Hospital and its services, UAP and its many disciplines, and to see the model classroom. Since the majority of the agency's classrooms were in the Harbor area, many of the teaching staff lived in that vicinity. It was an event for some to come to Los Angeles. In fact, eight of the 84 teachers had never been to Los Angeles. Providing in-service education on special education would have been difficult to arrange without the resources of UAP, a unique assembly of professionals whose primary function is education and training.

Seminars

All agency teachers were assigned to attend eight weekly seminars. (See Appendix F for list of subject matter.) The sessions were held during the normal working hours, with transportation furnished by the Head Start agency. A majority expressed positive feelings about attending and found the topics helpful. Some of the teachers were resentful, felt little relevancy to their needs and stated the terminology used was too complicated.

Head Start had tied into a schedule that was designed for USC students. The audience displayed a dichotomy between the Head Start staff and the students. Head Start questions were concerned with what do we do in a given clasroom situation, behavior problems, minority concerns, whereas the students' questions related to theory.

Certificates from UAP will be given to the Head Start staff for completing the series.

Next year, 1974-1975, UAP will design an in-service program especially for Head Start; i.e., here-and-now classroom problems and their possible solutions, kinds of disabilities and implications for the classroom. Teachers and support services will be asked to assess their needs. Personally, I learned a great deal from the seminars.

Classroom Observation

Teachers will be released from classroom time on a formalized schedule for the total agency to visit and observe. There will be two demonstration classrooms next year. Observation at Children's Hospital by some of the teachers this year was quite successful, partly due to the informality and familiarity of a classroom.

Career Development

The career development component of Head Start is strengthened by this program. There is a shortage of professional personnel to develop the mainstreaming concept or teach new special education classes. While most graduates of teachers' colleges are begging for jobs, those who have majored in special education are being avidly sought after by school systems. This training will help these teachers to find better paying jobs in special education. Hopefully their newly-developing skills will result in a further pursuit of course work in special education.

Preventive Health Care

Teachers, being better equipped,can identify behaviors perceived as normal or abnormal. The integrated classroom accentuates differences while keeping similarities constant. This can help to clarify a range of development norms for the teacher. Early identification by the teacher

of possible handicapping conditions in children can be studied diagnostically at Children's Hospital and UAP for early assessment and treatment. Feedback to the teachers at Children's Hospital was prompt. This program points up the frustrations of other Head Start staffs in the length of time it usually takes to process a referral and receive a diagnosis.

The Teachers

When the two teachers agreed to this assignment, they spoke of their apprehensions and fears. They were more scared than the children coming to school for the first time. By the end of the program, both were pleased with what they had learned and were quite self-confident about their abilities. They had the unique experience as on-the-job learners in special education with private instruction. Teachers had questions such as *How do I manage this child?* or *Does this child function this way because of a medical problem?* It was a relief to the teachers at Children's Hospital to have the resources to answer these questions and to share in the responsibility. Daily support was given to them by the Child Development Supervisor.

A major weakness in the program was the inability of the teachers to speak Spanish. It gave the teachers the incentive to join a class in Conversational Spanish. It did seem to push the English-speaking Mexican-American parents into a dominant role. The teachers' dependency on them was a contributing factor to their feelings of involvement and responsibility for the class.

This teaching team requested a transfer to the new program at Harbor General Hospital, an assignment closer to their homes, as the freeway commuting was a great drain on their energies. They will staff this similar

program opening at Harbor General Hospital in the fall. (See Appendix K.) Their competencies are difficult to replace. The advantage of a new teaching team is that two more people will receive the training. One will speak Spanish. The disadvantage is starting all over again.

The Children

The ratio of adult helpers to children was one to three children. This is an important concern in an integrated classroom. The focus (only with ample numbers of adults) can be on all children; then the child who does not require special help will not get overlooked in the action. In addition to a regular education program, the children learned about health services on familiar grounds. The people who were their medical helpers were known to them as people, who also took the time to *play* with them in the yard. An integrated education and medical experience provided a relaxed atmosphere, less threatening for the child and parents because the setting and the people were familiar, friendly, and seen in other roles.

All the children will be followed up as to their progress in the elementary school year, 1974-1975, through home and school visitations by staff.

One of the handicapped children (Danny) will continue to require a special school. It is difficult for the parent to travel so great a distance to Children's Head Start for another year. Two, because of age and developmental lag, will remain for another year. The rest will attend kindergarten in regular public schools.

They have developed friendships which the parents say they will nurture. Since some will be attending the same schools, this will help continue the relationships between children and parents.

Services to Parents

The parents received support services that would not have been available in a regular Head Start class. Who could afford to have a psychiatrist, social worker, or nurse standing by? There are more community resources for welfare recipients. In many cases, low-income families who have to pay for health care postpone treatment because of financial hardship. The three welfare recipients, as well as the twelve poor families, received prompt quality care.

In the same building, while the Head Start class was in session, some parents would be in group or individual therapy. Parent meetings and workshops were held down the hall. Speech and feeding clinics and occupational therapy were available on the premises.

Parent education at this school was more directed and purposeful. Topics were chosen by the expressed interest of parents and staff assessment of needs. UAP expressed a desire to take a more active role in planning next year's program.

Services were available to other children in the families. In other Head Start programs, the Head Start child is the center of concern, due to limitations of staff and monies. At Chilren's Hospital, two older children received surgical repair; a suicide-bent father received counseling; a special school was found for a retarded child who had been left alone at home for many months. These problems may not have been revealed elsewhere or, if they were, could the resources be obtained as readily? The unusually close-knit relationship of the parent group, and that group to the classroom, led to ready disclosure of family dilemnas. Being in the hospital setting may have helped to establish trust and confidence.

On the last day of school, 15 children and 35 adults went on a bus to the beach for a picnic. Several had never seen the ocean. On the ride home, five of the parents cried, finding it difficult to say goodbye to the teachers and the school. They decided to get together over the summer at a parent's house and continue Head Start. If the parents of 1973-1974 still express an interest in Head Start, an alumni group could be formed.

The program projection for next year is to ask the *old* parents if they would welcome the *new* parents. They, as socializing agents, who have coped with their own reactions to their children and those parents of handicapped children, can be helpful in bridging the gap between the professionals and the new parents.

Due to the newness of the program this year, it was difficult to expand services. In the future, a parent-child observation class could be formed for children two years and up to Head Start age and for those above the income criteria. These groups are found at other F.D.C.E.C. Head Start locations and they are called *Early Start*. If reaching the children and the parents earlier is a factor in successful intervention, then this program would help.

Future Implications

Costs This venture has been economically advantageous. With the same operational costs as any other Head Start class, the tax dollar spent has been stretched to incorporate a wide range of services and benefits to the community. The medical services rendered by UAP and Children's Hospital were a considerable saving. The comprehensive health care provided to all the families far exceeded the $110 per handicapped child allowed by the government. The integrated demonstration classroom has served many populations in training and development.

Integration The integrated classroom does work! The handicapped factor had no significant negative effects in this setting. It does have conditions in the implementation of this program. The ratio of adults to children must be increased from the usual one-to-five of regular Head Start classes. Six handicapped to nine- non-handicapped was the ratio this year. The ratio would vary each year depending on the kinds of disabilities, which would effect the number of adults necessary in the classroom.

There was an observable acceptance of the handicapped children and their parents in the non-handicapped group. Perhaps one of the reasons for the lack of separateness is that they (and we) are all handicapped to some degree. One of my observations from eight years in Head Start is that low-income minorities are more apt to share and pool resources than middle-income minorities. This may be part of the explanation of why this parent group did become so cohesive and interdependent.

The hospital-based Head Start classroom gives evidence that mainstreaming can work at an early age. Perhaps it is the critical time for the involvement of the handicapped children and their families in an educational and supportive program. It helps society, in general, to face the facts of life, that all people are not created equal. Low-income families have found a rightful place in Head Start and to a much greater degree of comprehensive attention, in the Children's Head Start. For the first time, the poor are travelling first class.

Program Growth

The Children's Hospital class is already pre-enrolled for fall 1974. Five of the children are referrals from Children's Hospital, two are holdovers, and the rest are from the community. From the number of inquiries

a need is indicated for another class. An afternoon session will be proposed.

As an outgrowth of this program and its success, a second hospital-based Head Start classroom will open in September 1974 at Harbor General Hospital. It, too, is a training hospital, affiliated with University of California at Los Angeles. The program will be more encompassing. Under the aegis of our Head Start agency, there will be, in addition to the handicapped/non-handicapped Head Start classroom, a Child Development Center for the hospital's 3000 employees and the community, operating two shifts, 6:30 am to 11:30 pm. If there is a need,the center will be open 24 hours a day. This program will serve handicapped and non-handicapped children.

This model could be implemented across the nation. Just as two hospitals here were willing to incorporate the program, training hospitals elsewhere could be approached with a similar plan given the proven data of this pilot project.

Chapter VIII

SUMMARY

A mandate from the federal government to increase services by 10% to severely handicapped children was received by Head Start in the spring of 1973. Prior to this, Head Start had provided services to children with handicapping conditions such as poverty, nutritionally deprived, cognitively undernourished, as well as children from non-English speaking homes.

There was no advance provision for the training of teachers to understand handicapping conditions, their effects on the child and the family, and their implications for teaching. The major problem and responsibility of Head Start was how to comply with the government regulation and how to implement a training program in special education for the staff.

A liaison was formed with the University Affiliated Program and Children's Hospital to provide in-service education for Head Start staff in one of Los Angeles County Delegate Agencies for the year 1973-1974. University Affiliated Program, with many different disciplines represented on staff, is a department of Children's Hospital, serving as a resource and training center for students from many universities.

In conjunction with the training program an integrated handicapped/non-handicapped demonstration Head Start classroom was established in September 1973 in the University Affiliated Program building near Children's Hospital. The classroom provided University Affiliated Program with an on-site training placement for their students and professional

staff to observe the similarities and differences, abilities and disabilities of young children in relation to their discipline. The classroom provided a unique opportunity for the medical staff to gather data for medical assessment from actual observation of the functioning levels and abilities of the handicapped child.

There were fifteen families attending Children's Head Start, six of whom were handicapped, and two siblings of handicapped patients referred by Children's Hospital. They received comprehensive health care and an educational program regarding preventive measures to insure good health. The remaining seven children were non-handicapped from the neighborhood of the hospital.

This demonstration class will continue for the year 1974-1975 and a second will open at Harbor General Hospital. The success of this intervention program providing social adjustment and education of the handicapped at an early age suggests that the time factor is significant.

Because of all the benefits that are derived from a hospital-based Head Start demonstration classroom, which meets the exact operational costs of any other Head Start classroom, it does appear that this model might well be duplicated across the nation.

BIBLIOGRAPHY

Allen, F.H. and Pearson, G.H.J. "The Emotional Problem of the Physically Handicapped Child." British Journal of Medical Psychology, 1928.

Barker, R.G. Adjustment to Physical Handicap. New York: Social Science Research Council, 1953.

Barsch, R.H. Management of the Child with Learning Disabilities. San Rafael, Calif.: Academic Therapy Publications, 1969.

Begab, M.J. "The Mentally Retarded Child." Washington, D.C.: Government Printing Office, 1963.

Begab, M.J. "Management of the Child." Pittsburg, Pa.: ACLD, 1967.

Bowlby, J. Maternal Care and Mental Health. Geneva, Switzerland: World Health Organization, 1952.

Carlson, P.V. and Greenspoon, K. "Visual Training for Children with Perceptual-Motor Learning Problems." American Journal of Optho-mology, 1968.

Coe, M.R. "A Summary of Parent's Needs." Management of the Child with Learning Disabilities: An Interdisciplinary Challenge. New York: ALCD Annual Conference, 1967

Cooley, C.H. Human Nature and Social Order. New York: Charles Scribner, 1922.

Cowan, P.A. "Cognitive Egocentrism and Social Interaction." Children-American Psychologist, 1966.

Cruickshank, W.A. Teaching Method for Brain-Injured and Hyperactive Children. New York: Syracuse University Press, 1061.

Cruickshank, W.A. and Johnson, G. Education of Exceptional Children and Youth. New York: Prentice Hall, Inc., 1958.

Deaver, G. "The Total Needs of the Handicapped Child." Conference on Crippled Children. Delaware: Nemours Foundation, 1956.

Dunn, L.M. Problems and Issues of Exceptional Children. Boston: Houghton Mifflin Co., 1971.

Erikson, E. "The Meaning of Play." Child Psychotherapy. Mary Haworth, ed. New York: Basic Books, Inc., 1964.

Barber, B. Family Organization with Handicapped Children. Monograph of the Survey for Research in Child Development, 1960.

Felsenthal, H. The Child and His Image. K. Yamamoto, ed. Boston: Houghton Mifflin, Co., 1972.

Fox, R.F. Priorities Steps in the Development of Integrated Psychiatric Services. New York, 1960.

Goffman, E. Asylums: Essays of the Social Situation of Mental Patients and Other Inmates. Garden City, New York: Anchor Press, 1961.

Hurley, R. Poverty and Mental Retardation. New York, Random House, 1969.

Jackson, D.N. and Messick, S. Problem in Human Assessment. New York: McGraw Hill, 1967.

Jones, Reginald L. Problems and Issues in Education of Exceptional Children. Boston: Houghton Mifflin Co., 1969.

Kirk, S.A. Early Education of Mentally Retarded. Urbana, Illinois: University of Illinois Press, 1958.

Kirk, S.A. Research in Education. Chicago: University of Chicago Press, 1964.

Koch, R. and Dobson, J. The Mentally Retarded Child and His Family. New York: Brunner/Mazel, Inc., 1971.

Landis, C. and Bolles, M. Personality and Sexuality in the Physically Handicapped Woman. New York, 1942.

Lerner, J.W. Children With Learning Disabilities. Boston: Houghton Mifflin, Co., 1971.

Macmillan, D.L. Problems and Issues in the Education of Exceptional Children. Boston: Houghton Mifflin Co., 1971.

Mink, L. "Adoption of the Montessori Method with the Special Child." Special Child in 21st Century. Seattle: Special Child Publication, 1964.

Moore, O.K. The Special Child in 20th Century. Seattle: Special Child Publication, 1964.

Murphy, L. The Widening World of Childhood. New York: Basic Books, Inc., 1962.

Murphy, L. and Leeper, E. The Vulnerable Child. Washington, D.C.: U.S. Department of Health, Education and Welfare Publication, 73-1030, 1973.

Mussen, P.H. and Barber, R.G. "Attitudes Toward Cripples." Journal of Abnormal and Social Psychology. Palo Alto, Calif.: Stanford University Press, 1944.

Peter, L.J. Prescriptive Teaching. British Columbia, Canada: University of British Columbia; McGraw-Hill Book Co., 1965.

Rosenthal R. and Jacobson, L. "Teacher Expectancies: Determinants of I.Q." Gains Psychological Reports, 1966.

Rosewell, F. and Natchez, N. Reading Disability - Diagnosis and Treatment. New York: Basic Books, Inc., 1967.

Rubin, E.Z., Seneson, C.B. and Betwee, M.C. Emotionally Handicapped Children in the Elementary School. Detroit: Wayne State University Press, 1966.

Schiffman, G.B. Interdiciplinary Approaches and Learning Disorders. New York: Chilton Book Co., 1970.

Schild, S. The Mentally Retarded Child and His Family. New York: Brunner/Mazel, Inc., 1971.

Sexton, P. Education and Income. New York: Charles Scribner, 1961.

Silberman, C. Crisis in the Classroom. New York; Black and White, 1964.

Tyson, M. "Pilot Study of Remedial Visuomotor Training." Special Educator, Vol. 52, 1963.

Weikart, D. et al. High/Scope Educational Research Foundation. Ypsilanti, Michigan, 1971.

Whitsell, A.J. and Whitsell, L.J. "Remedial Reading in a Medical Center". The Reading Teacher. May, 1968.

Wolfensberger, W. "Diagnosis Diagnosed." Problems and Issues, 1971.

Yamamoto, K. The Child and His Image. Boston: Houghton Mifflin Co., 1972.

1972 Amendments to the Economic Opportunity Act. (P.L. 92-242)